

FEDERAL BUREAU OF VITAL STATISTICS

National Office of Vital Statistics

FILED OCT 26 1948

Registration District No. 294

MISSOURI DIVISION OF HEALTH
STANDARD CERTIFICATE OF DEATH

Primary Registration District No. 3056

State File No. 33770

Registrar's No. 259

1. PLACE OF DEATH:

(a) County Randolph

(b) City or town Moberly
(If outside city or town limits, write "RURAL" and name of township)

(c) Name of hospital or institution:
1107 Bond
(If not in hospital or institution, write street number or location)

(d) Length of stay: In hospital or institution _____
(Specify whether _____)

In this community _____
years, months or days

3. (a) PRINT FULL NAME Arabine Hale

3. (b) If veteran, ☒ name war _____

3. (c) Social Security No. ✓

4. Sex Female

5. Color or race White

6. (a) Single, widowed, married, divorced Widow

6. (b) Name of husband or wife John J. Frohock

6. (c) Age of husband or wife if alive _____ years

7. Birth date of deceased Jan 25 1855
(Month) (Day) (Year)

8. AGE: Years 93 Months 8 Days 22
If less than one day _____ hr. _____ min.

9. Birthplace Me
(City, town, or county) (State or foreign country)

10. Usual occupation At home

11. Industry or business _____

12. Name John J. Frohock

13. Birthplace Me
(City, town, or county) (State or foreign country)

14. Maiden name Pracina Rhodes

15. Birthplace Me
(City, town, or county) (State or foreign country)

16. (a) Informant Mrs O. B. Shirley

(b) Address Moberly, Mo

17. (a) Burial (b) Date thereof 10-20-48
(Burial, cremation, or removal) (Month) (Day) (Year)

(c) Place: burial or cremation Moberly Mo

18. (a) Signature of funeral director Malcolm and Son

(b) Address Moberly Mo

19. (a) Oct 20-48 (b) Leah Williams
(Date received local registrar) (Registrar's signature)

2. USUAL RESIDENCE OF DECEASED:

(a) State Missouri (b) County Randolph

(c) City or town Moberly
(If outside city or town limits, write "RURAL")

(d) Street No. 1107 Bond
(If rural, give location)

(e) Citizen of foreign country? _____ (Yes or No)

If yes, name country _____

MEDICAL CERTIFICATION

20. DATE OF DEATH: Month Oct day 17th
year 1948 hour _____ minute 45 P.M.

21. I hereby certify that I attended the deceased from Oct 17th 48, 19____, to Oct 17 48, 19____;

that I last saw her alive on Oct 17th 1948
and that death occurred on the date and hour stated above.

Immediate cause of death Hypertensive Heart Disease
Acute failure

Due to Arterio-sclerosis

Due to _____

Other conditions _____
(Include pregnancy within 3 months of death)

Major findings:
Of operations _____

Of autopsy _____

22. If death was due to external causes, fill in the following:

(a) Accident, suicide, or homicide (specify) _____

(b) Date of occurrence _____

(c) Where did injury occur? _____
(City or town) (County) (State)

(d) Did injury occur in or about home, on farm, in industrial place, in public place? _____

While at work? ✓ (Specify type of place) _____
Means of injury _____

23. Signature Leah Williams (M. D. or other) _____
Address Moberly Mo Date signed 10-20-48

WRITE PLAINLY—USE UNFADING BLACK INK—MAKE A PERMANENT RECORD

MOTHER, FATHER

RECEIVED

District Health Officer No. 10

Charter File Number 10-48-1828

Date Filed OCT 25 1948

STATEMENT BY LICENSED EMBALMER

I hereby certify that the body whose name is recorded on the reverse side of this certificate was embalmed by me, or by.....

....., Registered Apprentice No.....
working under my personal supervision.

Signed.....

Frank S. DeWitt

Licensed Embalmer No. 3121

P. O. Address.....

Proby Mo

Note: The above MUST BE SIGNED BY THE LICENSED EMBALMER in his OWN HANDWRITING. (Failure to comply with the above constitutes grounds for revocation of license.)

If this body is not embalmed, fact should be so stated above.